Arizona Medical Board
9545 E. Doubletree Ranch Road,
Scottsdale, AZ 85258
(480) 551-2761 Fax (480) 551-2704
Email: renewals@azmd.gov

BIENNIAL MD LICENSE RENEWAL APPLICATION

LICENSE FEE: $500 (if postmarked by due date)
$850 (if postmarked 30 days after due date)

Review your Profile before completing this renewal form. If any of the information contained on the profile is incorrect, please print a copy, line-out the erroneous information, write-in the corrected information and submit with your renewal.

THIS LICENSE RENEWAL CONTAINS THE FOLLOWING:

- **Instructions (two pages)**
- **Biennial MD License Renewal Application Form (three pages)**
- **List of Field of Practice Codes (one page)**
- **Arizona State University Physician Workforce Survey (one page)**

USE THE CHECKLIST BELOW TO HELP ENSURE YOUR APPLICATION IS COMPLETE BEFORE MAILING

HAVE YOU:

- ☐ Provided address/phone number on page 1 of the license renewal application?
- ☐ Completed all sections and answered all questions on all 3 pages of the license renewal application?
- ☐ Provided a written explanation for each "yes" answer? (see special instructions on pages 2 and 3 of the application)
- ☐ Listed your ABMS Certifications/Practicing and corresponding Field of Practice Codes?
- ☐ Reviewed your internet physician profile and updated it, if needed?
- ☐ Provided a signature and date in all required places on all completed forms?
- ☐ Enclosed a completed ASU Physician Workforce Survey? (optional)
- ☐ **Enclosed proof of citizenship or alien status (See Statement of Citizenship and Alien Status Form on website under new Arizona License)**
- ☐ Enclosed your payment, in the form of a check, money order or Credit Card Authorization? **(Renewal form and payment must come together)**

REMEMBER: There is a $25 fee for reprocessing a deficient renewal:
Double-check your completed application before mailing

QUESTIONS: Contact renewals@azmd.gov or call (480) 551-2761.

INSTRUCTIONS: Biennial MD License Renewal Application and Associated Forms

- **PROVIDE OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**: The office/principal place of business address and phone number will appear in the Medical Directory and on the board's website. Every physician must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public. If you want your home address to be listed on your profile on the website please so indicate, otherwise no address will be provided on the profile.

- **PROVIDE MAILING ADDRESS:** Provide Mailing address if different from Office or Home.

- **PROVIDE HOME ADDRESS:** Notwithstanding any law to the contrary, a professional's residential address and residential telephone number or numbers maintained by the professional board established pursuant to this title are not available to the public unless they are the only address and numbers of record. This information will NOT be posted on our website but will be provided upon request.

PLEASE NOTE: You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. §32-1435(B) & (D). There is a fine of $100 for failure to report change of address.

- **AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:** Please review and correct the fields of practice and ABMS board certification information as shown on your profile. Only certifications from the American Board of Medical Specialties (ABMS) will be shown. Select the appropriate codes from the attached list of "**Field of Practice Codes**". "Board Certified" must be checked "**yes**" for you to be identified as "board certified" in the Medical Directory or on the Board's website. If certified since your last renewal, please attach a copy of ABMS certificate or letter.

- **REQUEST FOR CHANGE IN LICENSE STATUS:** You may request INACTIVATION or CANCELLATION of your license using this form, if applicable. **Do not submit a license renewal fee if you are requesting inactivation or cancellation, however you must sign and date the form. Please note that you must be totally retired from the practice of medicine to inactivate your Arizona MD license.**

- You may request INACTIVE STATUS if you are not presently under investigation by the Board, the Board has not commenced any disciplinary proceedings against you, and you are totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country. You understand that once inactive status is granted, the board will waive the annual renewal fees and requirements for CME. You further understand that you may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as your license is classified as inactive. You further understand that if you request reactivation of your license, you may be required to pass the SPEX examination and that the board may require any combination of physical examination, psychiatric, psychological evaluations and interviews it deems necessary to determine your ability to safely engage in the practice of medicine. A.R.S. §32-1431

- You may request CANCELLATION of your license if you are not presently under investigation by the Board; the Board has not commenced any disciplinary proceedings against you; and that you are requesting cancellation for the reason that you are no longer practicing medicine in the State of Arizona.

- **ATTESTATION AND SIGNATURE**: Review the attestation statements in this section, and provide a dated signature to certify, under penalty of perjury, that the statements are true. Specifically:

  - **All information submitted on and with this renewal application is true.** THIS INCLUDES INFORMATION AND RESPONSES PROVIDED ON ALL THREE PAGES OF THE RENEWAL APPLICATION, ANY CORRECTIONS MADE TO THE ENCLOSED PHYSICIAN PROFILE, AND ANY INFORMATION PROVIDED ON OR SUBMITTED WITH, THE A CME AUDIT FORM.

  - **I have completed a minimum of 40 credit hours of continuing medical education during calendar years 2006 and 2007 as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.**

  - **I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close, as required by A.R.S. §32-3211.**

****PLEASE NOTE: RECENT LEGISLATION -** It is unprofessional conduct for a "Health Professional," including a physician to fail to have a written protocol for secure storage, transfer and access of the patients' medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. The written protocol must address how the "Health Professional" intends to allow requests from patients for copies of their record or access their medical records. It also requires licensing agencies to verify by renewal the physician has protocol in place. This new law can be found on the Board's Web site at "http://www.azmd.gov" and selecting "Other law applicable to medicine"

- **Effective January 1, 2008, based on Federal and State Laws, all applicants must provide evidence that the applicant is lawfully present in the United States.** Federal law, 8 U.S.C § 1641, and a state law, A.R.S. § 1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and alien status available on the website.

- **QUESTIONS 1 THROUGH 13**: Answer each question, and then refer to special instructions located directly below the section containing these questions.

- **CONFIDENTIAL QUESTIONS 1 THROUGH 5**: Answer each question, and then refer to special instructions located directly below the section containing these questions. Your responses to these questions will not be released to the public.

- **PHYSICIAN PROFILE:** Review your internet physician profile prior to completing this renewal. If any of the information contained on the profile is incorrect, please print the profile, line-out the erroneous information, write-in the corrected information and return with your renewal form. You are subject to discipline if you provide erroneous information. **Please note that name changes must be requested in writing under a separate cover. Please see requirements and form on our website at www.azmd.gov under Physician Center – Additional Forms – Legal Name Change Form.** We are unable to list credentials other than M.D.

- **IF YOU RECEIVED NOTICE ON YOUR RENEWAL YOU WERE AUDITED FOR CME AUDIT: *DO NOT SUBMIT CME DOCUMENTATION UNLESS IT WAS INDICATED ON YOUR RENEWAL NOTICE.*** If indicated you were audited a CME Audit Form and documentation of CME completed for the two previous years of renewal must be submitted with your completed renewal. Please refer to Arizona Administrative Code R4-16-101 in your current medical directory or on our website to review allowable CME activities. At least 10% of all licensed physicians will be selected to receive a CME audit form for the past two calendar years at time of biennial renewal. If you have been assigned additional CME by the board, the CME you report at time of renewal must be in addition to the board-assigned CME.

FEES/PAYMENT: You may pay by check, money order or credit card. **There is a $25 fee for dishonored checks returned to us by the bank.** We cannot accept post-dated checks. **RENEWAL AND PAYMENT MUST COME TOGETHER. IF RECEIVED SEPARATE IT WILL BE RETURNED AS DEFICIENT.**

MAKE FEES PAYABLE TO: AZ MEDICAL BOARD (U.S. dollars only)

FAX COMPLETED RENEWAL WITH CC AUTHORIZATION FORM TO: 480-551-2704

OR MAIL TO:
ARIZONA MEDICAL BOARD
9545 E. DOUBLETREE RANCH ROAD
SCOTTSDALE, AZ 85258

IMPORTANT: There is a $25 fee for reprocessing a deficient renewal. Use the checklist included on the first page of the application packet to help you ensure your application is complete.

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: **Renewal Fee: $500 $850** (if postmarked 30 days after due date)

Name: **, MD**

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER

Phone #: **Fax #:**

E-Mail:

MAILING ADDRESS

HOME ADDRESS

Phone #:

Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

Field of Practice Code (see attached form for code)	**ABMS Certified? (Y/N)**	**Practicing? (Y/N)**	**Expiration Date** (or indicate lifetime certificated)

REQUEST FOR CHANGE IN LICENSE STATUS:

- ❑ **INACTIVE STATUS** (I have read and meet the requirements for Inactive status as listed in the instructions)
- ❑ **CANCELLATION** (I have read and meet the requirements to cancel my license as listed in the instructions)

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and

- I have completed a minimum of 40 credit hours of continuing medical education during the previous two calendar years of my renewal as required by A.R.S. §32-1434 and A.A.C. § R4-16-101
- I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. §32-3211

☐ **I am a U.S. Citizen or U.S. National** (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

☐ **I am NOT a U. S. Citizen or U.S. National** (If this box is checked you must download, complete and submit with your application "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents i. e. Alien Registration Card, Visa, etc.)

Signature of Licensee (Signature stamp will not be accepted) Date

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☐
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☐
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐	NO ☐
4. Since your last renewal have you had any healthcare license revoked?	YES ☐	NO ☐
5. Since your last renewal, have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☐
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☐
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	YES ☐	NO ☐
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☐
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐	NO ☐
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☐
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☐
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☐
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☐

Note: ***In the event the response to any of the questions numbered 1 through 13 is "YES"*****,** you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

Name: _____ License Number: _____

Signature: _____

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1. Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	YES ☐ NO ☐
2. Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	YES ☐ NO ☐
3. Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below.	YES ☐ NO ☐
4. Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?	YES ☐ NO ☐
5. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? **Ability to practice medicine is to be construed to include all of the following:** 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments; 2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids. "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.	YES ☐ NO ☐

In the event you answer YES to any of the above questions**,** you must file with the renewal a detailed written narrative statement concerning the above matter(s), including the name and address of healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. **Statement from attending physician must come with your renewal.** Treatment records must be sent directly to the board.

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR RENEWAL AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

• Evaluation/Treatment records • Psychiatric/Psychological records • Compliance reports from state monitoring programs

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.
FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Name: _____ License Number: _____

Signature: _____

FIELD OF PRACTICE CODES

AR	Abdominal Radiology	ID	Infectious Disease	PS	Plastic Surgery
AS	Abdominal Surgery	IM	Internal Medicine	PSH	Plastic Surgery Within the Head & Neck
ADM	Addiction Medicine	MPD	Internal Medicine/Pediatrics	PRO	Proctology
ADP	Addiction Psychiatry	IC	Interventional Cardiology	P	Psychiatry
AMI	Adolescent Medicine (Internal Medicine)	LM	Legal Medicine	PYA	Psychoanalysis
ADL	Adolescent Medicine (Pediatrics)	MFM	Maternal & Fetal Medicine	MPH	Public Health & General Preventive Medicine
OAR	Adult Reconstructive Orthopedics	MG	Medical Genetics	PCC	Pulmonary Critical Care Medicine
AM	Aerospace Medicine	MDM	Medical Management	PUD	Pulmonary Disease
A	Allergy	MM	Medical Microbiology	RO	Radiation Oncology
AI	Allergy & Immunology	ON	Medical Oncology	RP	Radiological Physics
ATP	Anatomic Pathology	ETX	Medical Toxicology (Emergency Medicine)	R	Radiology
PTH	Anatomic/Clinical Pathology	PDT	Medical Toxicology (Pediatrics)	REN	Reproductive Endocrinology
AN	Anesthesiology	PTX	Medical Toxicology (Preventive Medicine)	RHU	Rheumatology
BBK	Blood Banking/Transfusion Medicine	MGG	Molecular Genetic Pathology (Medical Genetics)	SP	Selective Pathology
CTS	Cardiothoracic Surgery	MGP	Molecular Genetic Pathology (Pathology)	SM	Sleep Medicine
CD	Cardiovascular Disease	OMO	Musculoskeletal Oncology	SCI	Spinal Cord Injury
PCH	Chemical Pathology	MSR	Musculoskeletal Radiology	ESM	Sports Medicine (Emergency Medicine)
CHP	Child and Adolescent Psychiatry	NPM	Neonatal-Perinatal Medicine	FSM	Sports Medicine (Family Practice)
CHN	Child Neurology	NEP	Nephrology	ISM	Sports Medicine (Internal Medicine)
DDL	Clinical & Laboratory Dermatological Immunology	NDP	Neurodevelopmental Disabilities (Pediatrics)	OSM	Sports Medicine (Orthopedic Surgery)
ALI	Clinical & Laboratory Immunology (Allergy & Immunology)	NDN	Neurodevelopmental Disabilities (Psychiatry & Neurology)	PSM	Sports Medicine (Pediatrics)
ILI	Clinical & Laboratory Immunology (Internal Medicine)	NS	Neurological Surgery	PMM	Sports Medicine (Physical Medicine & Rehabilitation)
PLI	Clinical & Laboratory Immunology (Pediatrics)	N	Neurology	CCS	Surgical Critical Care (Surgery)
CBG	Clinical Biochemical Genetics	NBN	Neurology/Diagnostic Radiology/Neuroradiology	SO	Surgical Oncology
ICE	Clinical Cardiac Electrophysiology	NP	Neuropathology	TTS	Transplant Surgery
CCG	Clinical Cytogenics	RNR	Neuroradiology	TRS	Trauma Surgery
CG	Clinical Genetics	NM	Nuclear Medicine	UM	Underseas Medicine & Hyperbaric Medicine
CMG	Clinical Molecular Genetics	NR	Nuclear Radiology	U	Urology
CN	Clinical Neurophysiology	NTR	Nutrition	VIR	Vascular & Interventional Medicine
CLP	Clinical Pathology	OBS	Obstetrics	VM	Vascular Medicine
PA	Clinical Pharmacology	OBG	Obstetrics & Gynecology	VS	Vascular Surgery
CRS	Colon & Rectal Surgery	OM	Occupational Medicine	OS	OS/Other
CFS	Craniofacial Surgery	OPH	Ophthalmology		OS/Acupuncture
CCA	Critical Care Medicine (Anesthesiology)	ORS	Orthopedic Surgery		OS/Administrative Medicine
CCM	Critical Care Medicine (Internal Medicine)	OSS	Orthopedic Surgery of the Spine		OS/Ambulatory Medicine
OCC	Critical Care Medicine (Ob/Gyn)	OTR	Orthopedic Trauma		OS/Artificial Joint Surgery
PCP	Cytopathology	OTO	Otolaryngology		OS/BioEngineering
DS	Dermatologic Surgery	NO	Otology/Neurotology		OS/Bone Marrow Transplant
D	Dermatology	APM	Pain Management (Anesthesiology)		OS/Clinical Research
DMP	Dermatopathology	PMR	Pain Management (Physical Medicine & Rehabilitation)		OS/College Health
DBP	Developmental-Behavioral Pediatrics	PMD	Pain Medicine		OS/Cosmetic Surgery
DIA	Diabetes	PLM	Palliative Medicine		OS/Electrophysiology
DR	Diagnostic Radiology	PDA	Pediatric Allergy		OS/Environmental Medicine
EM	Emergency Medicine	PAN	Pediatric Anesthesiology		OS/Forensic Medicine
END	Endocrinology, Diabetes & Metabolism	PDC	Pediatric Cardiology		OS/HIV/Aids
EP	Epidemiology	PCS	Pediatric Cardiothoracic Surgery		OS/Hypertension
FRS	Facial Plastic Surgery	CCP	Pediatric Critical Care Medicine		OS/Hypnosis
FM	Family Medicine (Formerly FP Family Practice)	PEM	Pediatric Emergency Medicine (Pediatrics)		OS/Immunopathology
OFA	Foot and Ankle, Orthopedics	PE	Pediatric Emergency Medicine (Emergency Medicine)		OS/Industrial Medicine
FOP	Forensic Pathology	PDE	Pediatric Endocrinology		OS/Interventional Radiology
PFP	Forensic Psychiatry	PG	Pediatric Gastroenterology		OS/Medical School Management
GE	Gastroenterology	PHO	Pediatric Hematology/Oncology		OS/Military Practice
GP	General Practice	PDI	Pediatric Infectious Disease		OS/Mohs Surgery
GPM	General Preventive Medicine	PN	Pediatric Nephrology		OS/NeuroOphthalmology
GS	General Surgery	PO	Pediatric Ophthalmology		OS/Nuclear Cardiology
FPG	Geriatric Medicine (Family Practice)	OP	Pediatric Orthopedics		OS/Pediatric Dermatology
IMG	Geriatric Medicine (Internal Medicine)	PDO	Pediatric Otolaryngology		OS/Psychosomatic Medicine
PYG	Geriatric Psychiatry	PP	Pediatric Pathology		OS/Research
GO	Gynecological Oncology	PDP	Pediatric Pulmonology		OS/Resident Education
GYN	Gynecology	PDR	Pediatric Radiology		OS/Rhinology
HS	Hand Surgery	PRM	Pediatric Rehabilitation Medicine		OS/Surgical Assisting
HNS	Head & Neck Surgery	PPR	Pediatric Rheumatology		OS/Therapeutic Radiology
HEM	Hematology (Internal Medicine)	NSP	Pediatric Surgery (Neurology)		OS/Total Joint Replacement/Arthritis Surgery
HMP	Hematology (Pathology)	PDS	Pediatric Surgery (Surgery)		OS/Travel Medicine
HO	Hematology/Oncology	UP	Pediatric Urology		OS/Tropical Medicine
HEP	Hepatology	PD	Pediatrics		OS/Urgent Care
HOS	Hospitalist	PHM	Pharmaceutical Medicine		OS/Vitreo-Retinal Surgery
IG	Immunology	PM	Physical Medicine & Rehabilitation		OS/Wound Healing

The Arizona State University Center for Health information and Research, in collaboration with the Arizona Medical Board is conducting this survey to gather research and form State policy regarding health information technologies in Arizona.

Name: _____, MD **AZ License #: _____**

1. How would you best characterize your practice? (*please do not check more than two*)

☐ Fully Retired (skip to end)	☐ Community Health Center	☐Government (VA, IHS, etc.)
☐Semi–retired / On Leave	☐Group Practice	☐Administrative Medicine
☐Med school, intern, resident, fellow)	☐Solo Practice	☐Academic/Teaching/Research
	☐Hospitalist	

2. Which of the following are available in your practice location? (check all that apply)

   ☐Email ☐Internet (Web) ☐Fax ☐Medifax ☐None of the above

3. How do you submit your bills to payers? (check all that apply)

   ☐Fax ☐Email ☐Via Internet ☐U.S. Mail ☐Don't Know

4. Are patient's medical records in your practice/organization stored as:

   a. paper files ☐Yes ☐No scanned images of paper files ☐Yes ☐No

   b. electronic files (electronic medical records) on PCs or a central server ☐Yes☐No (skip to #5)

      1. Are the records stored on ☐PC/ server located in your organization **or** ☐ on a server to which you connect via the internet? ☐ Don't Know
      2. Is your EMR system connected to: (check all that apply)

         a.☐Hospital ☐Pharmacy ☐Lab ☐Radiology center ☐None of these
      3. Are you the person who decided to purchase an electronic medical record system?

         a) ☐ Sole Decision Maker ☐ Shared Decision ☐ Decided by Others
         b) What is a reasonable amount to pay for an electronic medical record system (per individual provider within a practice setting)? ☐$5000–$10,000/ provider ☐$10,000–$20,000/ provider ☐>$20,000 per provider

      (go to question # 6)

5. Are you the person who would decide to purchase an electronic medical record system?

   a. ☐ Sole Decision Maker ☐ Shared Decision ☐ Decided by Others (skip to end)

   b. Would you consider an Internet-based system (patient records stored offsite) rather than one where the records are stored in your office pc or server? ☐Yes ☐No

   c. What is a reasonable amount to pay for an electronic medical record system (per individual provider within a practice setting)? ☐$5000–$10,000/ provider ☐$10,000–$20,000/ provider ☐>$20,000 per provider

6. Would you be willing to participate in a web based system that permits the exchanges of medical records among health care providers? ☐Yes ☐No (skip to end)

   a. Who would you trust to manage the health information exchange system ?(check all that apply) ☐Commercial vendor ☐ Health insurer/managed care plan ☐Hospital system ☐Other ☐Regional health information organization (RHIO) ☐State of Arizona (AHCCCS)

☐PLEASE SEND ME A COPY OF THE RESULTS
THANK YOU FOR COMPLETING THIS SURVEY

ARIZONA MEDICAL BOARD

PAYMENT CARD AUTHORIZATION
MD BIENNIAL LICENSE RENEWAL

Payment for: _____, MD **AZ License #:**

☐ **$500 if postmarked by DUE DATE** ☐ **$850 if postmarked 30 days after DUE DATE**

Type of Card: ☐ **Visa** ☐ **MasterCard**

Card #: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Expiration Date: ☐☐ - ☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address and Phone Number of Cardholder: (Required)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number of Cardholder: _____

Mailing Address of Cardholder: (If different from billing address):

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature of Cardholder: _____ **Date:** _____

Please complete and return this form *with your license renewal documents* if paying by credit card
Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258
Or Fax to: 480-551-2704

*(If you fax your form and fee payment, **DO NOT** mail in the originals as you may be charged a second time. Thank you!)*